TENNESSEE DEPARTMENT OF HUMAN SERVICES
HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION

Information will be released for: **PRINT NAME►**	**Date:**	**Identify Signer:** ☐ Self ☐Parent of minor ☐Guardian ☐Other authorized representative (explain) * Proof of legal authorization may be required.
Street Address		**(Parent/guardian sign here if two signatures required by State law)**

Phone Number (with area code) **( )**	**City**	**State**	**Zip**

I give permission for the following medical/health records about me to be sent to the Tennessee Department of Human Services (TDHS) and its authorized agents/contractors. The records will be used to help decide if I will be eligible for services or benefits.

- ***Specific Description of medical/health information to be provided*** **(Additional approval required for certain records*)

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- ***TDHS can also get drug or alcohol treatment/referral records: Yes:_____ No:____**
- ***TDHS can also get HIV/AIDS test/treatment records: Yes _____ No:_____**
- ***TDHS can get my medical/health information from the following persons/organizations:***

_____

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- **For the medical/health records I have given permission to be disclosed, TDHS can talk to, or ask to get copies of my medical/health records from, my doctors, hospitals, clinics, nursing homes,, or any other private or government health care providers, or insurance companies and public or private health plans or any other person, agency or company that has my medical/health information.**
- **I give permission to TDHS to use a paper copy or copies of this form to get my medical/health information. They can also use a computer or electronic and/or fax copy of this form.**

YOU DO NOT HAVE TO SIGN THIS FORM. ***If you do not sign this form or if you take back your permission, TDHS may not be able to decide your case on time or may have to deny your case.***

- I will get a copy of this form after I sign it. I can ask my doctors or hospital to let me see or copy the information sent to TDHS after I sign this form.
- **This permission is good for 12 months from the date I sign this form, unless I take back my permission sooner.**
- **You have the right to withdraw your permission at any time.** ***You cannot take back information that has been used to take action on your case or that has been given to us before you take back your permission.***
- **To take back your permission to let us get your medical/health records, you can *write* TDHS in your county, or *write* your doctors, hospitals or other health care providers or insurance company or health plan to take back your permission at any time.**
- All information about you that TDHS gets is protected by the Privacy Act of 1974 and federal or state law or regulations. It will not be given to other persons or organizations unless the law or regulations allow or require us to give out that information, or you allow us to give out that information. If we are required or permitted to give out the information about your medical/health records, it may not be protected if the person or organization that receives it is not required by law to protect the information.
- **We may also use your information when we compare records by computer.** The computer matches our information with other Federal, State or Local government agencies. Many agencies use matching information to find out if a person gets benefits paid by the Federal or State government. The matches also help prove that a person is eligible for help. The law lets us do this even if you do not agree to it.
- Ask TDHS to explain if you have questions about how or why your information is used.

Signature of Person or Person's Authorized Representative: _____ Date: _____

This authorization was developed to comply with the provisions regarding disclosure of medical/health information under P. L. 104-191 ("HIPAA"); 45 Code of Federal Regulations parts 160 and 164; 42 U.S. Code Section 290dd-2; 42 CFR part 2.31; 38 U.S. Code section 7332 and T.C.A § 68-10-113.